MATTERS ARISING

STD and inflammatory cervical cytology

The results as reported in the abstract of the paper *The association between sexually transmitted disease and inflammatory cervical cytology* by Dimian, *et al* (*Genitourin Med* **68**:305–6) are at odds with the data presented in the paper. Assuming the numbers reported for ectropion and wart virus infection in table 3 and in the body of the paper are correct, the associated odds ratios are:

Ectropion 2·00 (95% CI 1·3 to 3·3, p = 0·005)

WVI; Mild dyskaryosis: 0·51 (95% CI 0·28 to 0·93, p = 0·035).

Note also that the numbers of "moderate, severe dyskaryosis" in table 3 appear to be interchanged and that the p-value in the footnote is incorrect. Thus contrary to the results section, there is a significant association between inflammatory cytology and cervical ectropion and dyskaryosis, as well as with *Trichomonas vaginalis* and *Chlamydia trachomatis*. The results section of the abstract also states that "there was no association with chlamydia alone" and this too is at odds with the numbers presented in Table 2.

PETER SASIENI
Imperial Cancer Research Fund Laboratories,
PO Box 123,
Lincoln's Inn Fields,
London
W2A 3PX, UK

Dr Dimian and Dr Bradbeer reply:

There are several errors which we would like to correct. These result from the omission, at the request of the referee, of some of the data combined with two typographical errors.

Firstly, in order to explain our reference to dual infection with chlamydia and trichomonas, we would like to add the following table (left out at request of the referee) (table 4).

Table 4 Incidence of trichomonas (TV) and Chlamydia trichomatis (CT)

	Inflammatory n = 101 (%)	*Non-inflammatory n = 262 (%)*
TV alone	11 (10·9)	15 (5·7)
Chlamydia (CT) alone	11 (10·9)	15 (5·7)
Dual infection	7 (7)*	1 (0·4)

*p < 0·001.

In addition we would like to correct the results section (para 4) so that it reads "Although the prevalence of cervical ectropion was higher in patients with inflammatory smears, *when infections with chlamydia and trichomonas were excluded,* this difference was not statistically significant". This should be read in conjunction with the corrected table 3 as follows:

Table 3 Incidence of ectropion and dyskaryosis

	Inflammatory n = 101 (%)	*Non-inflammatory n = 262 (%)*
Ectropion	43 (42·6)	70 (26·7)*
Ectropion in the absence of TV and CT	31 (30·6)	59 (22·5)
WVI; mild dyskaryosis	15 (14·8)	67 (25·5)*
Moderate, severe dyskaryosis	5 (4·9)	13 (4·9)

*p < 0·05.

Because of these changes the results section of the abstract should read:

"Dual infections with chlamydia and trichomonas were significantly associated with inflammatory changes, but the association with chlamydia alone was not statistically significant. Over 90% of trichomonas infections were detected on cytology. Thus cervical cytology showing inflammatory changes without trichomonas was not significantly associated with sexually transmitted diseases. Dyskaryosis was negatively associated with inflammatory smears."

We do apologise for any confusion these errors may have caused, and thank Dr Peter Sasieni, of the Imperial Cancer Research Fund Laboratories, for bringing them to our attention.

Fournier's gangrene and HIV: wider issues

The curious publication of two articles by your journal at different times, each claiming to be the first to report Fournier's gangrene in a patient with HIV infection,[1 2] raises a number of points for debate. First, why publish single case reports simply documenting the occurrence of uncommon conditions in the context of HIV? Why shouldn't Fournier's occur in those with HIV? (It might be more noteworthy and fascinating if it didn't.) What is more important is whether it occurs with greater frequency in HIV, and whether the natural history is modified. A single case report is insufficient to address these questions. Paradoxically, by questioning whether the Nelson *et al*[1] case actually was a true example of Fournier's, Murphy and Mulcahy[3] reduce the force of their own earlier observation: a further report of this rare condition hints that the frequency may be increased in HIV, and should alert clinicians to this.

Although now much discussed, there is still too much pressure on doctors in training to publish. Much greater emphasis is placed on the number of publications on a CV than on their quality. Inevitably, single case reports and letters to journals are churned out.

This was a small oversight, made worse because both papers appeared in the same journal, and similar errors must be inevitable from time to time even in journals of the highest quality. Nonetheless, a further and more important issue which it provokes is that of quality management of medical journals in general. How could the existence of the earlier Murphy *et al* article have been missed by the later report's authors, referees and section editors?

In nearly all areas of medical practice we are now required to monitor quality, and institute change where necessary. Medical publishing, with its great responsibilities in the areas of medical and clinical education, is not excepted. Peer review is used by tradition to ensure the quality and suitability of articles for publication. Yet in general reviewers are anonymous, unpaid and unaccountable. By using more than one referee, a substandard response from a single reviewer may be identified, but this might be impracticable for small items including letters and single case reports.

Medical journals may need to consider whether managing the quality of their articles now requires a different approach. Has the time come for the names of reviewers to be identified or available on request? Should they be paid, and how should they be accountable?

G A LUZZI
Department of Genitourinary Medicine,
Wycombe General Hospital,
High Wycombe HP11 2TT

1 Nelson MR, Cartledge J, Barton SE, Gazzard BG. Fourniers gangrene following hyfrecation in a male infected with the human immunodeficiency virus. *Genitourin Med* 1993;**68**:401–2.
2 Murphy M, Buckley M, Corr J, Vinayagamoorthy S, Grainger R, Mulcahy FM. Fournier's gangrene of the scrotum in a patient with AIDS. *Genitourin Med* 1991;**67**: 339–41.
3 Murphy M, Mulcahy F. Fournier's gangrene and HIV disease. *Genitourin Med* 1993;**69**: 326–7.

Editors note:

We are grateful to Dr Luzzi for pointing out the flaws in our current peer review system. We are constantly trying to improve the peer review process and have now instituted a process for searching for papers of similar title and content prior to publication.

The quality of referees and their response is continuously monitored and we ask each of our referees to follow a set format when reviewing manuscripts. Unfortunately, from time to time, errors still occur. However, we trust this does not detract from the overall quality of the journal.

Mycoplasmas and non-gonococcal urethritis

Although *Mycoplasma genitalium* was discovered more than 10 years ago,[1] and was noted to have considerable pathogenic potential,[2] there has been little information about its role in disease because of the great difficulty in culturing it. However, the advent of the polymerase chain reaction (PCR) technique has made detection of *M genitalium* possible and we[3 4] and Jensen *et al*[5] have reported recently on its significant association with non-gonococcal urethritis (NGU). It is clear that the strength of the